Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Individual/Family| **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. Please read the State Employee Health Plan Summary Plan Description that contains the complete terms of this plan. For general definitions of common terms, such as **allowed amount, balance billing, coinsurance, copayment, deductible, provider**, or other bolded terms please call 1-800-332-0307.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$500** per Individual / **$1,000** per Family. Non-Network: **$700** per Individual / **$1,400** per Family. Doesn't apply to preventive care.	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes, preventive care.	For example, this **plan** covers certain **preventive services** without cost-sharing and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Medical and Pharmacy combined Out of Pocket: Network: $6,650 Ind / $13,300 Family Non-Network $6,650 Ind / $13,300 Family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premiums**, **balance-billing** charges, and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. For a list of preferred providers, see **www.bcbsks.com** or call 1-800-332-0307 .	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **non-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**).
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	
	Specialist visit	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	
	Preventive care/screening/immunization	$0 copayment	Not covered	Colonoscopies, Mammograms, and Pap Smears - Not limited to once per year / in network 100% regardless of diagnosis. Immunizations with Non Network providers covered in full up to age 6 only.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	Discount to member when using preferred labs (Quest or Stormont Vail).
	Imaging (CT/PET scans, MRIs)	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Deductible plus 20% coinsurance (retail or mail order)	Deductible plus 20% coinsurance on the plans allowed charge	First fill is a 30 day supply at retail and mail. A 90 day supply is allowed at retail and mail for subsequent refills. **Deductible:** $500 Individual / $1,000 Family. **Out-of-Pocket Maximum:** $6,650 Individual / $13,300 Family **Contraceptives:** Covered with 0% member coinsurance **Non-Preferred Contraceptives:** Covered subject to 65% member coinsurance. Compound medications covered only at a Network Pharmacy.
	Preferred brand drugs	Deductible plus 40% coinsurance (retail or mail order)	Deductible plus 40% coinsurance on the plans allowed charge	
	Non-preferred brand drugs	Deductible plus 65% coinsurance (retail or mail order)	Deductible plus 65% coinsurance on the plans allowed charge	
	Specialty drugs	Deductible plus 40% coinsurance **per 30 day supply**.	----none----	All fills must be filled through CVS Caremark Specialty (1-800-237-2767).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	Prior authorization is required
	Physician/surgeon fees	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	Prior authorization is required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Deductible plus 50% coinsurance	Deductible plus 50% coinsurance	Must meet emergency criteria
	Emergency medical transportation	Deductible plus 50% coinsurance	Deductible plus 50% coinsurance	Must meet emergency criteria
	Urgent care	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	Prior authorization is required
	Physician/surgeon fees	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	Prior authorization is required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	
	Inpatient services	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	Prior authorization is required for inpatient services. For help call New Directions at 1-800-952-5906.
If you are pregnant	Office visits	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	
	Childbirth/delivery professional services	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	Prior authorization required for stays longer than 48/96 hours
	Childbirth/delivery facility services	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	Prior authorization required for stays longer than 48/96 hours
If you need help recovering or have other special health needs	Home health care	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	Prior authorization may be required
	Rehabilitation services	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	Prior authorization required
	Habilitation services	Not covered	Not covered	Unless under the Autism Rider of the policy
	Skilled nursing care	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	Prior authorization required
	Durable medical equipment	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	Prior authorization required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Hospice services	Deductible plus 50% coinsurance	Deductible plus 60% coinsurance	Prior authorization may be required. Inpatient Hospice care limited to 6 months.
If your child needs dental or eye care	Children's eye exam	$0 copayment for first annual visit, then deductible plus 50% coinsurance	Deductible plus 60% coinsurance	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your Benefit Description for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery (to improve appearance of normal body structure)
- Hearing Aids
- Private-duty nursing

Other Covered Services (Limitation may apply to these services. This isn't a complete list. Please see your Benefit Description.)

- Bariatric surgery (for qualified patients)
- Hearing Exam to determine hearing loss and newborn screening
- Non-emergency care when traveling outside the U.S. See www.bcbs.com/already-a-member/coverage-home-and-away.html
- Nutritional Evaluation and Diabetes Management

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: COBRAGuard at 1-866-952-6272. You may also contact your state insurance department, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance **Marketplace**. For more information about the **Marketplace**, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information to submit a **claim**, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact: Customer Service at 1-800-432-3990 or you can visit www.bcbsks.com/blueaccess, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español):	Para obtener asistencia en Español, llame al	1-800-432-3990
Tagalog (Tagalog):	Kung kailangan ninyo ang tulong sa Tagalog tumawag sa	1-800-432-3990
Chinese (中文):	如果需要中文的帮助，请拨打这个号码	1-800-432-3990
Navajo (Dine):	Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'	1-800-432-3990

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist coinsurance	50%
Hospital (facility) coinsurance	50%
Other coinsurance	50%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	**$12840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$6150
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6710**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist coinsurance	50%
Hospital (facility) coinsurance	50%
Other coinsurance	50%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	**$7460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$3592
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$4147**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist coinsurance	50%
Hospital (facility) coinsurance	50%
Other coinsurance	50%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	**$2010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$963
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1463**

The plan would be responsible for the other costs of these EXAMPLE covered services.